



# ALLEN ACADEMY

## "As Needed" Medication Administration Request 2017-2018

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Student Weight: \_\_\_\_\_

Medication	Symptoms to give medication for	Dose (ml,tsp,etc.)	Time interval between doses	Special Instructions or precautions

I, the undersigned parent/guardian of \_\_\_\_\_ request the above medication(s) be administered to my child when deemed necessary by the school nurse. I also give permission to my child's teacher and/or administration to administer the same medication as prescribed above in the absence of the nurse and/or on field trips during the school year. This medication has been prescribed by a licensed physician or purchased by me for my child and I hereby release Allen Academy and its employees from any and all liability that may result from my child taking the above medication(s).

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**\*Please send all as needed medications in their original packaging either in prescription bottle as released from pharmacy or in original box and bottle if OTC.**

**\*Prescription medications appropriately labeled and in their original container will stand as physician signature.**